Patient Consent to the Use and Disclosure of Health Information

I, hereby give consent to ***Steinberg Diagnostic Medical Imaging (SDMI)*** to use and disclose protected health information (PHI) about me for planning my care and treatment, payment and health care operations.

I understand and have been provided with a *Notice of Privacy Practices (NPP)* that includes a complete description of SDMI's uses and disclosures of my PHI and I understand that I have the right to review the NPP prior to signing this consent. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that ***SDMI*** reserves the right to change their NPP and prior to implementation, in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"). I understand that I may pick up a copy from any SDMI location or download from www.sdmi-lv.com.

I understand that I may be contacted via email, telephone, and/or text message about my healthcare with SDMI on my preferred number (mobile number) provided to SDMI. I consent to SDMI contacting me on my mobile number for the purpose of appointment reminders, current/future healthcare information, payment, and/or feedback on my experience. I understand that these messages may exceed more than 3 times/weekly. I understand that I may opt out of receiving text messages to the mobile phone number provided by responding STOP in response to text messages; this will only STOP the current type of message. To STOP all communication to mobile device, please email us at stoptext@sdmi-lv.com.

I authorize the request and release of health information to the following person(s), which I designate as my personal representative. By appointing these individual(s) as personal representative(s), I understand that I am authorizing SDMI to give the individuals access to health information and the right to talk to SDMI about my medical care. I understand I have the right to revoke this authorization at any time. I understand that if I revoke an authorization I must submit the written notification to complianceofficer@sdmi-lv.com, and that any revocation will not apply to the extent that the organization has already take action in reliance thereon. I also understand that the revocation will not apply to my insurance company when the law provides my insurance company with the right to contest a claim under my policy.

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Patient's Signature

_____
Date